Mobility Assistive Equipment -- Face to Face Examination Report

Patient Information					
Name					Medicare (HICN)#:
Mailing Address:					Telephone:
City:	State:	Zip:	DOB:	Age: 220	SSN:
Physician or Treating Practitioner Information					
Name:					Date of Last Visit:
Mailing Address:					Telephone:
City:			State:		Zip:

Current Symptoms, Related Diagnoses and History

Please describe the reason for this mobility evaluation

_____

_____

_____

_____

Please list previously diagnosed conditions that relate to the current office visit

_____

_____

_____

_____

Physical Exam				
Ht:	Wt:	B/P:	Pulse (resting):	Respiratory: Normal Labored at times Is O_2 required? **Y** **N**

Any current pressure sores? **Y** **N** Location: _____

Poor Balance: **Y** **N** History or Risk of Falls: **Y** **N** Poor Endurance: **Y** **N**

Cachexia (severe weakness): **Y** **N** Obesity: **Y** **N** Significant Edema: **Y** **N**

Holds to furniture/walls for mobility: **Y** **N**

Neck, Trunk and Pelvic Posture and Flexibility ____ Good ____Limited ____Severely Limited

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Functional Assessment

	Question	Your Answers below must be justified by your narrative responses.	
1.	Does your patient have a mobility limitation that impairs participation in Mobility Required Activities of Daily Living (MRADLs) in the home? If YES, why: _____	☐ YES	GO TO QUESTION 2
		☐ NO	STOP – NO MAE
2.	Can their limitations be compensated by the addition of MAE to improve the ability to participate in MRADLs in the home? If YES, why: _____	☐ YES	GO TO QUESTION 3
		☐ NO	STOP – NO MAE
3.	Is your patient or their caregiver capable and willing to operate the MAE safely in the home?	☐ YES ☐ NO	GO TO QUESTION 4 STOP – NO MAE
4.	Can their mobility deficit be safely resolved by a cane or walker? If NO, why: _____	☐ YES	STOP – ORDER CANE OR WALKER
		☐ NO	GO TO QUESTION 5
5.	Does your patient's home environment support use of a wheelchair or POV? (Home assessment to be completed by Medical Equipment Supplier)	☐ YES ☐ NO	GO TO QUESTION 6 STOP – NO MAE
6.	Does your patient have the upper extremity function to safely propel a manual wheelchair to participate in MRADLs in the home? If NO, why: _____	☐ YES	STOP – ORDER MANUAL WHEELCHAIR
		☐ NO	GO TO QUESTION 7
7.	Does your patient have sufficient strength and trunk stability to operate a POV in the home? Please Explain:_____	☐ YES	GO TO QUESTION 8
		☐ NO	GO TO QUESTION 9
8.	Is your patient able to safely maneuver a POV in their home?	☐ YES ☐ NO	STOP – ORDER POV GO TO QUESTION 9
9.	Does your patient need the additional features (i.e. optimal maneuverability, ease of use, upgradeable/adaptable-seating, etc.) of a power wheelchair to paticipate in MRADLs in the home? If YES, why: _____	☐ YES	GO TO QUESTION 10
		☐ NO	STOP – NO MAE
10.	Is your patient safe and able to maneuver a power wheelchair in the home?	☐ YES ☐ NO	STOP – ORDER PWC STOP

The information provided is a true and accurate representation of my patient's current condition. I hereby incorporate this document into my patient's medical record. This document is supported by additional medical records in my patient's file.

Physician or Treating Practitioner Signature:_____ **Date:**_____